National Association of State EMS Officials
201 Park Washington Court Falls Church, VA 22046-4527 www.nasemso.org
703-538-1799 fax 703-241-5603 info@nasemso.org

. TESTIMONY OF ROBERT BASS ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE EMERGENCY MEDICAL SERVICES OFFICIALS BEFORE THE TRANSPORTATION AND INFRASTRUCTURE COMMITTEE AVIATION SUBCOMMITTEE HEARING ON HELICOPTER MEDICAL SERVICES APRIL 22, 2009

Good morning Chairman Costello and Ranking Member Petri. I am Dr. Robert Bass and am testifying on behalf of The National Association of State Emergency Medical Services Officials (NASEMSO) which is the lead national organization for state EMS directors, medical directors, trauma managers and other officials charged with building, leading, and regulating our statewide systems of emergency medical response. I am the Chair of NASEMSO's Air Medical Committee and direct the Emergency Medical Services (EMS) system in Maryland.

EMS and Trauma Systems save lives. A breakdown in those systems can cost lives. In previous decades, helicopter EMS (HEMS) Programs were well integrated into our trauma and EMS systems. Today, in many parts of the country, that integration is lacking due in large part to the explosive growth of the HEMS industry during the past decade and the ensuing competition for business. Additionally, as states have attempted to address HEMS competition, establish medical standards, and regulate patient care, they are frequently challenged under the Airline Deregulation Act (ADA). The end result of all of this is that patients' lives are being put at risk by delayed and uncoordinated transports, unsafe practices, insufficient medical equipment, and inappropriate medical care.

How did we get to a broken air medical system?

From the early 1970's, when civilian air medical services began in the United States, through the year 2000, there was a slow but steady growth of air medical services. They were generally non-profit, hospital-based or governmentally-sponsored helicopter programs. The growth was slow because air medical services were expensive to operate and not well reimbursed by health insurance. This slow growth allowed sufficient time to integrate of HEMS programs into complex state and local EMS systems.

In the early 2000's, shortly after Medicare improved it's reimbursement practices for HEMS, the industry began to experience extraordinary growth in the number of medical helicopters throughout the country (see Figure 1). We began to see a shift from mostly non-profit hospital-based or government providers to for-profit operators of independently based helicopters which then consolidated into large, national or regional companies. The number of medical helicopters more than doubled from under 400 in 2000 to 840 by 2008. Texas is now served by 90 medical helicopters, while Pennsylvania has 62, and Florida has 61. Oklahoma has increased from three

bases and four aircraft in 2000 to 25 bases and 34 aircraft today. More helicopters doesn't always mean more access – in many cases it simply meant more helicopters on top of each other in an unregulated, competitive, and potentially dangerous environment. This unprecedented growth in the number of HEMS aircraft posed significant challenges to state and local EMS systems as they attempted to integrate and regulate HEMS programs across the country.

In modern EMS systems, a request through 9-1-1 for emergency medical assistance results in a complex and often highly choreographed response by dispatchers, EMS responders, hospital personnel, and other resources. Changes in this system must be carefully planned and coordinated. Since 2000, however, the rapid injection of hundreds of new and frequently independently operated medical helicopters into existing state and local EMS systems has created enormous coordination challenges and confusion. When new operators are able to establish HEMS operations wherever and whenever they choose, EMS systems frequently may have insufficient time or the means to establish standards for accessing, dispatching, coordinating, and safely utilizing these services. Additionally, efforts to address these issues have been challenged under the ADA. The mere introduction of a new medical helicopter into an EMS system does not automatically mean that lives will be saved. To the contrary, it may mean that lives will be lost, especially if an appropriate mechanism for state medical regulatory oversight is not in place.

The chilling effect of ADA preemption challenges on state regulation

There are HEMS operators who would prefer to avoid state regulation, establish their own medical standards, serve whomever they choose (particularly those who are insured) and place their bases wherever they want regardless of whether there is a need in that community for additional HEMS services. Such operators have been utilizing the ADA preemption provision through the use of threats or actual litigation in an attempt to dismantle various state EMS and health planning provisions across the country including in Minnesota, Missouri, North Carolina, Pennsylvania, Hawaii, Florida and Texas.

- In one recent US Department of Transportation (DOT) opinion, they recognized the authority of states to regulate basic staffing requirements, qualifications of personnel, equipment requirements and sanitary standards.

- However, in another DOT opinion, requirements related to "quality, availability, accessibility and acceptability" were viewed as being preempted by the ADA. Regulating such items as oxygen masks, litters, blankets and trauma supplies was found permissible, but the DOT cautioned the state that regulations "ostensibly dealing only with medical equipment/supplies aboard the aircraft could be so pervasive or so constructed as to be indirectly regulating the economic area of air ambulance prices, routes, or services." This language leaves states unclear as to the extent to which they can require medically necessary but expensive equipment without it constituting indirect and prohibited economic regulation. And it raises the significant question as to whether a HEMS operator who doesn't want to pay for an expensive cardiac monitor or ventilator required by a state could simply argue they are priced out of the market and that the requirement should be preempted under the ADA.

- State efforts to require that HEMS providers operate 24/7, provide services where there is a need, serve anyone (regardless of whether they have purchased a membership), and establish

primary geographic service areas, have all been ruled impermissible by either a court or the DOT.

- State certificate of need (CON) and similar laws have been routinely preempted, thus impeding the ability of states to appropriately plan and coordinate emergency medical services. Missouri once had a CON requirement for HEMS, and still does for other health care services. But since the State can no longer determine the number or location of HEMS service providers, there are now 31 helicopters in the state, many right on top of each other in Kansas City and St. Louis. Numerous coordination problems exist, such as the refusal of some operators to move their helicopter off of a hospital helipad for an incoming helicopter transporting a patient to that hospital.

The impact of ADA related judicial decisions and DOT letters has not only frustrated on-going efforts of many state EMS regulators attempting to address the safe and effective utilization of HEMS, but future efforts as well. State EMS offices frequently cite the ADA as an obstacle to effectively regulating HEMS and are unclear as to what regulations are permissible, in particular since the DOT letters have been inconsistent in there interpretation of the ADA. Further, they are concerned about time consuming, costly, and damaging lawsuits, and as a result, enforcement of existing regulations and implementation of new and stronger regulations have been curtailed substantially in many states.

Air ambulances are not merely air taxis and therefore must not be regulated that way

The difference between aircraft operations transporting passengers and those transporting patients are important.

First, while a medical helicopter is an air carrier, first and foremost, it is an ambulance. HEMS providers do not simply transport patients between two points, they provide sophisticated patient care that must be overseen by physicians and performed within the context of the overall EMS system.

Second, while airline passengers typically choose their mode of transport and airline, EMS patients and their families generally cannot. Patients need public protection because they are not traditional consumers who can make choices based on quality, service, or price.

Third, unlike most air transport services that interact principally with other components of the broader aviation system, HEMS providers must function as part of another system – the EMS system – in order to save lives. Air medical service providers are but one component of a state's EMS system and must routinely interact with a variety of emergency, public safety, and health care personnel and operations.

State regulation of HEMS is about more than the just care provided inside the helicopter

Thirty six states have CON or equivalent laws and some of the remaining sixteen states have some form of regulation of health care services. Less than ten states apply their CON or equivalent laws to HEMS providers and several of those have been struck down either through litigation or DOT opinion letters such as Minnesota, Missouri, Hawaii and most recently, North Carolina.

The North Carolina CON law, which no longer may apply to HEMS following recent litigation,

includes a legislative finding that is instructive as to the purpose of CON regulations:

> "…if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have been traditionally been medically underserved, would result." NCGS Section 131E-175 et seq.

The citizens of each state expect that their best interests will be protected by the state should they become sick or injured and require medical care, including air medical transport. State protection of "medical services" goes far beyond regulation of the equipment, personnel and conditions *inside* the medical helicopter. States must also have clear authority to fulfill the public trust in planning, coordinating, integrating, and regulating air ambulances as a component of the overall EMS system, just as they do for ground ambulances. Not every state requires or will utilize all of this authority, but they should have the unambiguous authority to act to protect the public interest when the need arises. NASEMSO supports HR 978, and I would like to focus on a few key provisions of the bill that we view as critically important. HR 978 would provide states with the clear and unambiguous authority in:

- Determining the need for new HEMS programs and aircraft
- Determining the distribution of aircraft to ensure good statewide access
- Regulating the hours of service to ensure effective access and integration
- Making medical necessity determinations, coordinating flight requests, determining medically appropriate destinations, and ensuring HEMS communications with EMS systems
- Establishing requirements for the medical adequacy of aircraft that provide patient care which address factors such as provider access to the patient and climate control to protect vulnerable patients such as neonates and heart patients from temperature fluctuations during transport.
- Establishing minimum standards for the medical equipment necessary to treat critically ill and injured patients during transport, even if they are expensive and are "related to" the aircraft (e.g., ventilators, cardiac monitors and oxygenation that require electrical supply from the aircraft and must be affixed to it as well).

Dispelling concerns and misinformation about HR 978

We have heard some concerns raised about HR 978, so please allow me to address a few of them now:

First, we have heard opponents argue that the bill would limit access to HEMS services in rural and underserved areas. That is incorrect – it is certainly not our plan nor would it be in the public's interest to limit access to HEMS in rural or underserved areas. What we would potentially do is limit the number of helicopters in oversaturated markets, coordinate base locations and geographic service areas, and establish minimum medical standards. While I understand that doesn't please the opponents, it is in the best interest of ill or injured patients for whom it can mean the difference between life and death.

Second, HR 978 doesn't tell a state it must regulate, or that if it does regulate, that it must regulate in a certain way. The bill appropriately leaves that up to the states based on the needs of its citizens

and the availability and location of medical resources. Some have said the legislation should be more narrowly tailored. It already is very narrowly tailored -- it does not enable states to impose aviation safety requirements that the FAA has failed to impose such as radar altimeters, and it doesn't affect rates or prohibit subscription or membership programs.

Third, HR 978 does not impede interstate transport of patients. It only allows states to regulate transport point to point within the state. If a HEMS program is based in a bordering state but is going to provide routine transport for services within another state, all they need to do is get a medical license in that second state. Medical helicopters move across the borders every day just as ground ambulances do without any problem at all – HR 978 does nothing to change this.

Fourth, HR 978 does not interfere with the FAA's authority to regulate aviation safety. Both the federal government and the states are trying to protect the same patient – the FAA protects the patient from crashes and other flight safety issues and the states protect the patient from harm by improving access to and the medical care provided by HEMS programs. The need for aviation safety does not negate the need for patient safety. We recognize that state and federal regulations must be consistent and complementary and that any state requirements must not conflict with FAA safety requirements. We believe that HR 978 properly balances the state's traditional and essential role in regulating medical services while maintaining the FAA's role in regulating flight safety.

Conclusion

The federal government and states must improve the regulation of HEMS in a manner that will ensure that both aviation safety and patient safety issues are sufficiently addressed. NASEMSO recognizes the essential role of the FAA in regulating air carriers and aviation safety, but strongly believes that more clearly defined federal and state roles and authority would lead to safer and more effective utilization of HEMS in the United States. NASEMSO further believes that federal authority and preemption under the ADA must be clarified to give states the unambiguous authority to protect the public interest as it relates to the medical oversight of HEMS programs. The ''Helicopter Medical Services Patient Safety, Protection, and Coordination Act'', HR 978, would accomplish much of this and we strongly urge its enactment.

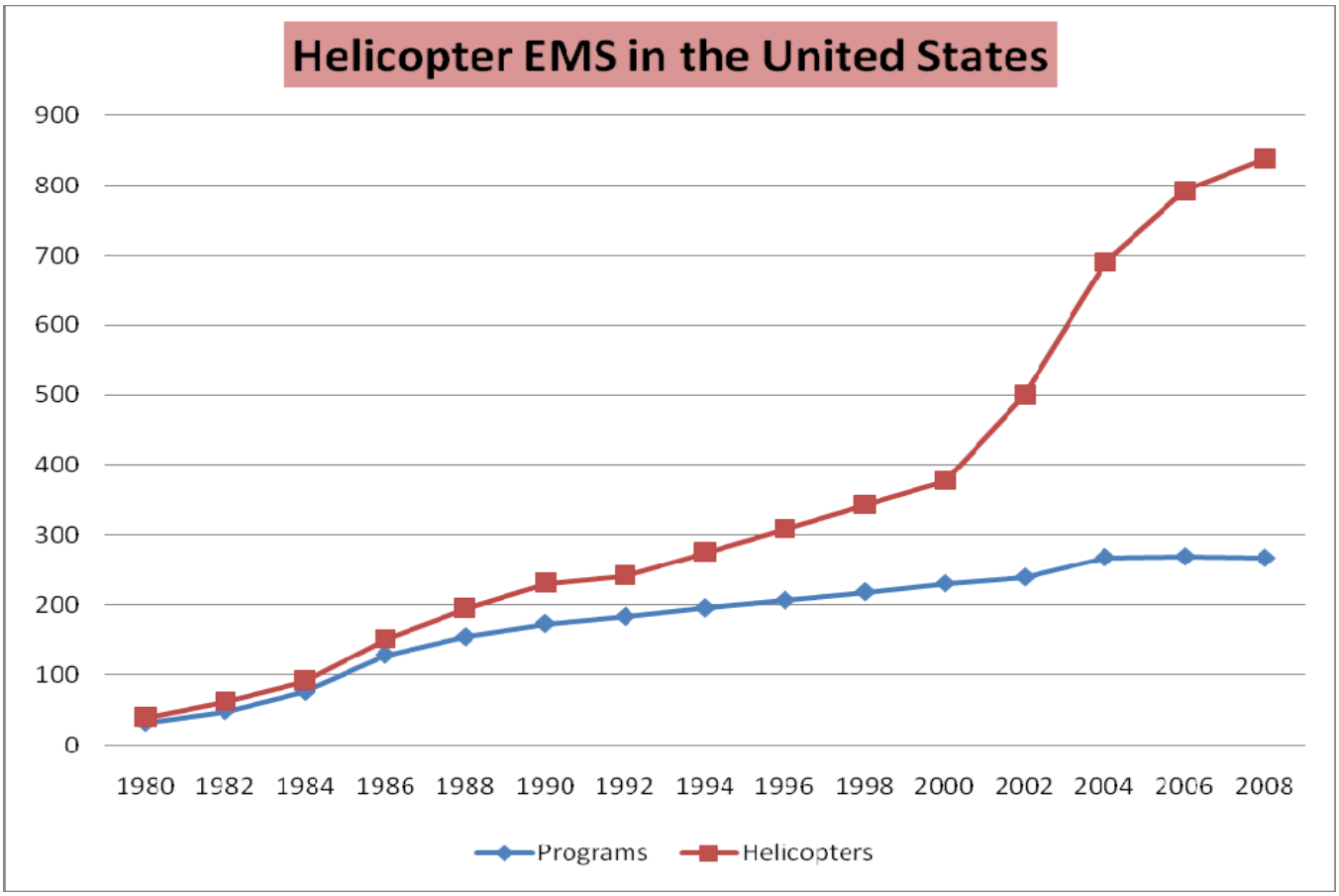

Figure 1 (Figures derived from joint consensus paper of the Association of Air Medical Services, NASEMSO, and the National Association of EMS Physicians: McGinnis KK, Judge, T et al *Air Medical Services: future development as an integrated component of the Emergency Medical Services (EMS) System: a guidance document*; Prehosp Emerg Care. 2007 Oct-Dec;11(4):353-68 Accessed in December, 2008 at: http://www.nasemso.org/Projects/AirMedical/. 2008 data point is from ADAMS 2008 accessed at: http://www.adamsairmed.org/pubs/AMTC08_poster.pdf in February, 2009.)